

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-015703

STATE FILE NUMBER

23976

FILED MAY 6 1959

Registration District No.

Primary Registration District No.

Registration No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. LOUIS		c. CITY OR TOWN ST. LOUIS	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR CITY HOSPITAL # 1		d. STREET ADDRESS (If outside, give location) 3225 NO. FLORISSANT	
Length of stay in lb 67 YRS		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Theodore Middle Last SCHWARZE		4. DATE OF DEATH Month 8 Day 21 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT 4, 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) MAINTENANCE MAN		10b. KIND OF BUSINESS OR INDUSTRY CEMETERY	9. AGE (In years last birthday) 81 YR
11. BIRTHPLACE (City and state or country) BIELEFELD, GERMANY		12. CITIZEN OF WHAT COUNTRY? USA	
13a. FATHER'S NAME HENRY SCHWARZE		13b. MOTHER'S MAIDEN NAME MARIE UFFMAN	
14. NAME OF HUSBAND OR WIFE NONE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT LITTLE SISTERS OF THE POOR	
Address 3225 No. Florissant Florissant		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Edema DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)	
INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour Month, Day, Year a.m. p.m.		20d. INJURY OCCURRED WHILE AT <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 4-12-1959 to 4-21-1959 and last saw her alive on 4-21-59 Death occurred at 7:15p.m. on the date stated above; and to the best of my knowledge, from the causes stated.		22a. SIGNATURE (Degree or title) Samuel W. Hays, MD	
22b. ADDRESS 1515 Lafayette Ave.		22c. DATE SIGNED 4-21-59	
23a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		23b. DATE 4-23-59	
23c. NAME OF CEMETERY OR CREMATORY ST. PETERS CEMETERY		23d. LOCATION (City, town, or county) (State) ST. LOUIS COUNTY, MISSOURI	
24. FUNERAL DIRECTOR BEIDERWIEDEN F.H. INC., 1936 ST. LOUIS AVE		25. DATE RECD. BY LOCAL REG. APR 22 '59	
26. REGISTAR'S SIGNATURE Earl Smith, M.D.			

USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

MEDICAL CERTIFICATION

All diseases in Part I must be causally related.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed
by me, or by, Student Embalmer No.
working under my personal supervision.

Student
Signature of Student Embalmer

Signed

Homer W. Fritz

Licensed-Embalmer No.

3882

P. O. Address

St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.